A Appendix A: Healthy Connections (HC)

A.1 Healthy Connections (HC)

A.1.1 Overview

Healthy Connections (HC) is a primary care case management (PCCM) model of managed care. Healthy Connections helps Medicaid participants receive the care they need, when they need it, and at the appropriate place. The assurance of a familiar, consistent doctor and patient relationship creates a medical home. This is where participants receive the preventive and other basic health care needed to help promote good health.

The goals of HC are to:

- Ensure access to healthcare.
- Promote and protect the health of Medicaid participants.
- Emphasize continuity of care.
- Provide health education.
- Achieve cost efficiencies for the Idaho Medicaid Program.

Medicaid participant enrollment into HC is required in the majority of counties statewide. Individuals applying for Idaho Medicaid are asked to identify their current primary care provider (PCP) or choose a HC PCP.

A.1.2 Healthy Connections (HC) Provider Agreement

Idaho Medicaid providers of primary care services can participate in HC by signing a Coordinated Care Provider Agreement. This is in addition to the Idaho Medicaid Provider Agreement. Coordinated Care Provider Agreements are available from the Regional Health Resources Coordinators (HRC). Addresses and telephone numbers for the regional HC offices are listed in the *Directory* of this provider handbook, as well as on our HC Web site at: **www.healthyconnections.idaho.gov**.

Healthy Connections Primary Care Providers are required to furnish proof of medical liability insurance to the Department of Health and Welfare (DHW) as a condition of program participation. This can be accomplished by providing a Certificate of Insurance to HC staff when submitting the Coordinated Care Provider Agreement and on an annual basis thereafter.

Healthy Connections Primary Care Providers agree to:

- Provide primary care services.
- Exercise best efforts to monitor and manage the participant's care.
- Provide 24 hour telephone access to a medical professional.
- Make referrals when medically necessary services are not provided by the PCP.

To help ensure efficient operations, HC PCPs must report changes in their practice to HC staff immediately when:

- Providers either join or leave their practice.
- The practice moves, opens a new site or closes an existing site.
- The clinic name is changed.
- The federal tax ID is changed.
- The designated contact person is changed.

Dependent upon the extent of the change, a new Coordinated Care Provider Agreement may need to be executed.

Healthy Connection PCPs receive a monthly case management fee of $3.50 for each eligible Medicaid participant enrolled with them. (See *Section A.1.7.1 Case Management Fee*, for more information.)

A.1.2.1 Healthy Connection (HC) Primary Care Provider (PCP) Referral Number

When a PCP enrolls in HC, the PCP receives a HC referral number. This number is given in conjunction with the PCP's medical orders as part of making a referral to another provider for services. In order to be reimbursed, providers receiving referrals must enter the HC referral number on their claim. This indicates that they are providing services authorized by the HC PCP.

When billing for participants with both Medicare and Medicaid coverage, a Healthy Connections (HC) referral number is not required on the claim billed to Medicare, doing so may cause your claim to be denied by Medicare.

If Medicare covers the service, the claim is processed as a crossover claim. The HC edits do not apply to crossover claims. If Medicare does not cover the service, the claim is not processed as a crossover claim. The HC edits do apply to non-crossover claims that are subsequently submitted to Medicaid and will require the HC referral number on the claim. See *Section A.1.4 Healthy Connections (HC) Referrals*, for more information.

A.1.3 Participant Enrollment and Disenrollment

Enrollment in HC is prospective and always begins the first day of the month. Each enrolled participant is sent a written notice advising him of the name, phone number, and address of their PCP. This notice is sent prior to the effective date of the HC enrollment.

A.1.3.1 Choice of Primary Care Provider (PCP)

Medicaid participants may choose a PCP in one of the following ways:

1. Indicate their choice of PCP on the Application for Assistance when they apply for Medicaid.
2. Complete and return a HC Enrollment form received in the mail from DHW.
3. Complete a HC Enrollment form at the PCP's clinic, which then sends the form to the regional HC office.
4. Call the regional HC office to enroll over the phone.

Family members are not required to choose the same PCP. If a participant requires assistance in choosing a PCP, the regional HRC can provide information regarding available PCPs and will assist the participant in making a selection.

Enrollment at PCP Office: Always check eligibility and HC enrollment prior to providing services. If a Medicaid participant is not enrolled with your HC clinic, please have them complete an enrollment form before they leave your office and mail or fax it to the regional HC office. Enrolling participants at your clinic will help avoid the possibility of them being assigned to a different HC PCP and help ensure you receive your case management fee.

A.1.3.2 Assignment of Primary Care Provider (PCP)

Enrollment in HC is mandatory for most Medicaid participants. Exemptions from enrollment are described in, *Section A.1.3.3 Exemptions from Participation*.

When a Medicaid participant does not choose a PCP and the participant lives in a mandatory participation area, DHW assigns the participant to a HC PCP. The HC PCPs in mandatory participation areas have agreed to provide a medical home for every individual who becomes Medicaid eligible. As part of this agreement, a rotational assignment schedule is adopted.

The assignment process is initiated when the participant did not choose a PCP on the Medicaid application and does not respond to a request to choose a PCP. If after ten days the participant does not choose a PCP, the HRC will assign the participant to a PCP according to the rotational schedule agreed to by the PCPs. When the HRC is able to determine a current relationship with a PCP through claims history, the participant will be enrolled with that PCP.

A.1.3.3 Exemptions from Participation

Medicaid participants not enrolled in HC include those who:

- Reside in a long-term care setting (in a nursing facility or an intermediate care facility (for developmentally disabled)/mentally retarded (ICF/MR)).
- Are eligible only as Qualified Medicare Beneficiary (QMB).
- Have chosen to receive benefits under the Medicare-Medicaid Coordinated Plan.
- Are on Medicaid lock-in status.

A participant may be exempt from mandatory enrollment for the following reasons:

- Has a verifiable pre-existing relationship with a non-participating PCP or clinic.
- Has incompatible third party liability.
- The participant wished to obtain obstetric (OB) services from an OB specialist during pregnancy and a HC OB is not available.
- Travel is more than 30 miles or 30 minutes to obtain primary care services from a HC PCP and there is a non-HC provider closer.

A.1.3.4 Participant Requested Disenrollment

Participants may request a change in their PCP. If the HRC is notified by the 20th of any month, the change will be effective the first day of the following month. Otherwise, the change is not effective for another month.

A.1.3.5 Provider Requested Disenrollment

The provider may dismiss an enrolled participant from their practice for the following reasons:

- The enrollee fails to follow the treatment plan.
- The enrollee misses appointments without notifying the provider (missed appointment policies for Medicaid patients must be the same as for all other patients).
- The enrollee and PCP relationship is not mutually acceptable (for instance, disruptive or uncooperative behavior not due to the enrollee's special needs).
- The enrollee's condition would be better treated by another provider.

The HC PCP must provide written notification to both the participant and the HRC at least 30 days prior to the intended disenrollment date. Disenrollment requests initiated by a PCP and received by the HRC before the 20th of the month will be dated the end of the month in which the notice is received by the HRC. Requests received after the 20th of the month will be effective the end of the following month. Any requests for disenrollment must be approved by the HRC prior to notifying the enrollee.

Federal regulations prohibit and the Coordinated Care Provider Agreement specifies that HC PCPs may not dismiss (or disenroll) an enrolled participant from their practice because of any of the following:

- A change in the enrollee's health status.
- The enrollee's utilization of medical services.
- The enrollee's diminished mental capacity.
- Uncooperative or disruptive behavior resulting from the enrollee's special needs, except where continued enrollment with the PCP seriously impairs the PCP's ability to furnish services either to the enrollee or other patients.

A.1.4 Healthy Connections (HC) Referrals

A.1.4.1 Overview

If the HC PCP determines that specialized services are necessary, the PCP refers the participant to a specialist for the services. Medicaid will pay for covered services received from another Idaho Medicaid provider with a referral from the HC PCP. All services requiring a HC referral that are rendered without a referral are considered non-covered services and will not be paid by the Medicaid Program.

Prior to performing any services, all Medicaid providers should check to see if the participant is Medicaid eligible and if they are enrolled in HC. When obtaining eligibility information, the provider should also request the name and telephone number of the HC PCP in order to obtain the appropriate referral to provide services. If no HC PCP is listed, no HC referral is needed.

All services require a referral except for those listed in *Section A.1.5 Services That Do Not Require a Primary Care Provider (PCP) Referral*.

A.1.4.2 Method of Referral

A referral is a doctor's order for services. HC PCPs can make a referral for a patient by:

- Filling out a DHW referral form and giving it to the patient to take to the specialist or sending it directly to the specialist.
- Ordering services on a prescription pad.
- Calling orders to the specialist.

A.1.4.3 Documentation of Referrals

Both the PCP and the provider being referred to must document the specifics of the referral in the participant's file. If the PCP has completed a referral form, a copy of the form should reside in the patient's file in both providers' offices. If another form of physician order or referral was used, such as a phone call or standing order, this information is also required to be in the patient's files and should include specifics of the referral or physician order.

Use of a PCP's referral number indicates that the billing provider has obtained and documented the referral in the participant's record. Using a referral number without obtaining a referral is fraudulent.

The details of the referral are to be documented in the patient's permanent record by both the referring provider and the provider to whom the referral was made. The record should include:

- Who made the referral.
- Date of referral.
- Scope of services to be provided (including authorization for the receiving providers to use the PCP's referral number to refer the participant to additional, related ancillary services).
- Referral number (for billing purposes).
- Duration of the referral.

A.1.4.4 Scope of Services Authorized

The scope of services authorized by a referral is determined by the PCP and defines the limitations of the referral. The following are examples:

- Number of visits authorized (*e.g.*, ten physical therapy visits).
- Time limit (*e.g.*, treat for three months).
- Diagnosis or condition related (*e.g.*, treat for developmental delay).

Questions regarding the scope of a referral should be directed to the PCP.

If a HC PCP routinely refers a participant to one specialty provider such as an allergist, the PCP can authorize a standing order. A standing order is subject to the same information and documentation requirements as any other referral.

The maximum duration of an HC referral or standing order is one year.

A.1.4.5 Medical Necessity

Primary Care Providers are required to make referrals for medically necessary services not provided by the PCP. The Department of Health and Welfare defines medical necessity for some services. Most common services that have Medicaid-defined medical necessity criteria are:

- Case management (service coordination).
- Developmental disabilities services.
- Psychosocial rehabilitation.
- Private duty nursing.
- Home and community based waiver services.

Healthy Connection Primary Care Providers cannot deny referrals for these services when a participant meets the Medicaid defined medical necessity criteria for the service.

A.1.4.6 Interim Referrals

In counties where HC is mandatory, PCPs are required to provide interim referrals for ongoing services that a participant may be receiving when the participant is assigned to the PCP by DHW but hasn't been seen by the PCP. The PCP must give the participant a reasonable amount of time to make an appointment to request a long-term referral.

A.1.4.7 Transfer of Care Referrals

When a participant changes PCPs, the HC PCP may give a transfer of care referral to the new PCP until the change is processed. This will facilitate services provided by the new PCP. Transfer of care referrals are only good for 30 days.

A.1.4.8 Three-Way Referrals

A HC PCP can authorize the specialist receiving a referral to order additional services on behalf of the PCP. For example, a referral to diagnose and treat authorizes the specialist to order tests to accomplish diagnosis and perform surgery, if necessary. In these cases, the specialist is to forward the referral information (including the referral number) to the service providers who need it (*e.g.* hospital or ASC).

A.1.4.9 Referrals to the Department of Health and Welfare (DHW)

Developmental disabilities (DD) and mental health (MH) services delivered under a plan of care are authorized by the PCP via referral to develop the plan of care. Department of Health and Welfare staff (or designee overseeing service delivery) is authorized to forward appropriate referral information to the various providers of service indicated in the approved plan of care.

A.1.4.10 Retroactive Referrals

Making a referral for services that have already been rendered by another provider is at the discretion of the PCP. If the PCP would have given the referral had it been requested prior to the provision of the service (such as in the case of medically necessary services not provided by the PCP), they can give the referral retroactively.

A.1.4.11 Feedback to Primary Care Provider (PCP)

Specialists or providers who receive HC PCP referrals are to report findings and progress back to the PCP unless the PCP indicates he does not want to receive such feedback.

A.1.5 Services That Do Not Require a PCP Referral

Anesthesiology Services:

Audiology Services: Performed in the office of and billed by a certified audiologist. Audiology basic testing requires a physician's order not necessarily from the PCP.

Chiropractic Services: Performed in the office. Medicaid will pay for a total of 24 manipulation visits during any calendar year, for remedial care by a chiropractor but only for treatment involving manipulation of the spine to correct a subluxation condition.

Dental Services: All dental services are exempt from referral. Pre-operative examinations for procedures performed in an inpatient-outpatient hospital setting or ASC setting should be performed by the PCP when possible. Otherwise, the exam requires a referral. Dental procedures may require a prior authorization (PA).

Emergency Department: Services provided in an emergency department (ED) of a hospital.

Family Planning Services: Provided by district health departments or other agencies providing counseling and supplies to prevent pregnancy.

Flu Shots: Not requiring an office visit.

Immunizations: Immunizations do not require a referral when they do not require an office visit. Specialty physicians and providers administering immunizations are asked to provide the participant's PCP with immunization records to assure continuity of care and avoid duplication of services.

Indian Health Clinic Services: For individuals eligible for Indian Health Services.

Laboratory Services (includes Pathology):

Long-Term Care: Nursing Facility (NF), ICF/MR.

> **Note:** Long-term care services are only covered for Medicaid Enhanced Plan participants.

Personal Care Services (PCS) and PCS Service Coordination:

> **Note:** Private duty nursing, nursing services, DD & Idaho State School and Hospital (ISSH) waivers, supervising registered nurse, and PCS are only covered for Medicaid Enhanced Plan participants.

Pharmacy Services: For prescription drugs only. Durable medical equipment (DME) provided by pharmacies always requires a referral and sometimes requires PA.

Podiatry Services: Performed in the office of and billed by a podiatrist. Procedures performed in an inpatient or outpatient hospital or ASC setting require a referral from the PCP for the facility and ancillary physicians/providers such as pre-operative exam by a physician.

Radiology Services:

School District Services: Includes all health related services provided by a school district under an individual education plan (IEP).

Screening Mammography: Limited to one per calendar year, for women age 40 and older.

Tests and Treatment for Sexually Transmitted Disease:

Transportation: Non-emergent, medical transportation to and from covered medical services if no other means are available.

Vision Services: Performed in the offices of ophthalmologists and optometrists, including eyeglasses. However, procedures performed in an inpatient or outpatient hospital or ASC setting require a referral from the PCP for the facility and ancillary physicians and providers such as, pre-operative exam by a physician.

Waiver Services for the Aged and Disabled (A & D)/Traumatic Brain Injured (TBI):

Note: Waiver services for the A & D and TBI participants are only covered for Medicaid Enhanced Plan participants.

A.1.6 Prior Authorization (PA)

In addition to a HC referral, some services also require PA. Prior authorization numbers must be included on the claim or the authorized service will be denied.

A.1.7 Payment

A.1.7.1 Case Management Fee

In addition to payment for services rendered, PCPs enrolled in HC are paid a monthly case management fee of $3.50 per month for each enrolled participant. This monthly case management fee is based upon the number of HC Medicaid participants enrolled in the practice during a calendar month regardless of whether or not the participant is seen during that month.

The case management fee payment is automatically generated to PCPs the first or second pay cycle of each month. Case management fees are included in a separate remittance advice (RA) named Case Maintenance Fee, and mailed separate from the weekly RA.

All other covered services provided for a HC participant are billed to EDS using the physician's Medicaid provider number. See *Section 2 General Billing* for more information.

A.1.7.2 Denials for HC Referral

All services requiring a HC referral that are rendered without a referral are considered non-covered services and will not be paid by the Medicaid Program.

The Medicaid provider agreement signed by all Medicaid providers specifies that in order to bill a Medicaid participant for non-covered services, the provider rendering the non-covered services must advise the participant prior to provision of such services that the Medicaid participant will be responsible for the bill. Providers may not balance-bill participants for services billed to Medicaid.

Claims submitted for services rendered to a PCP's own HC enrollees should never deny because they lack a HC referral (explanation of benefits - EOB **010** or **011**). This type of denial typically happens when the PCP has not reported that a new provider has joined the clinic. Primary Care Providers should contact EDS immediately if they are having trouble billing for their own patients.

A.1.7.3 Rosters

A roster of enrollees, which lists all new, ongoing, and disenrolled HC participants, is generated and mailed to PCPs each month. Participants listed on the roster may be enrolled in either the Medicaid Basic Plan or Medicaid Enhanced Plan.

A.1.7.4 Healthy Connections (HC) Primary Care Case Management (PCCM) Provider Enrollee Roster Field Descriptions

Report Field	Description
PAGE	Page number for reports.
RUN DATE	The date and time for reporting run time.
PERIOD	From date in MM/DD/CCYY format.
THRU	To date for reports in MM/DD/CCYY format.
COUNTY	Code identifying the county in which a participant resides.
REGION	Code indicating a geographic or geopolitical district of the state.
PROVIDER NUMBER	Provider's Idaho Medicaid HC number.

Report Field	Description
SL	Location where the provider rendered services.
PROVIDER NAME	First name of a HC Medicaid provider.
NONE	Middle initial of Medicaid provider.
NONE	Last name of a Medicaid provider.
NONE	Suffix for the provider's name (Jr., Sr., etc.).
MID	Participant's Idaho Medicaid identification (MID) number.
NAME	Last name of the participant.
NONE	First name of the participant.
NONE	Middle initial of the participant.
DOB	Date of birth of the participant.
PCP	Provider's Idaho Medicaid HC number.
SL	Service location where the provider rendered services.
START DATE	Date the participant began HC enrollment.
END DATE	Date the participant ended HC enrollment.
TOTAL NEW	Total number of new enrollments for a provider.
TOTAL ONGOING ENROLLEES	Total number of enrollments for a provider.
TOTAL DISENROLLMENT	Total number of disenrollments for a provider.
CURRENT ENROLLMENT	Current number of participants under the care of a HC provider.

A.1.7.5 Sample Healthy Connections (HC) Primary Care Case Management (PCCM) Provider Enrollee Roster

HCKR250 IDAHO MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE 1

RUN DATE: 02/27/2004 04:16 HC PCCM PROVIDER ENROLLEE ROSTER PERIOD: 03/01/2004 THRU 03/31/2004

COUNTY: 00

REGION: 01

PROVIDER NUMBER: 1234567 SL: 00 PROVIDER NAME: PRESIDENTIAL PRIMARY HEALTHCARE

MID	NAME			DOB	PCP	SL	START DATE	END DATE
NEW ENROLLEES - MEDICAID								
90000000100	ADAMS	JOHN	Q	02/20/1938			03/01/2004	12/31/2382
90000003100	ARTHUR	ELLEN	R	05/29/1968			03/01/2007	12/31/2382
90000003500	CLEVELAND	GROVER	L	01/12/1948			03/01/2004	12/31/2382
ONGOING ENROLLEES – MEDICAID								
90000005200	BUCHANAN	JAMES	L	01/14/1948			03/01/2004	12/31/2382
90000004400	COOLIDGE	CALVIN	R	12/24/1959			03/01/2004	12/31/2382
90000000900	MONROE	JAMES	R	10/21/1989			03/01/2004	12/31/2382
DISENROLLMENT – MEDICAID								
90000001400	EISENHOWER	DWIGHT	R	11/21/1989			03/01/2004	03/31/2004
90000009900	MCKINLEY	IDA	R	10/02/1972			03/01/2004	03/31/2004

TOTAL NEW: 3 TOTAL ONGOING ENROLLEES: 3 TOTAL DISENROLLMENT: 2 CURRENT ENROLLMENT: 6

A.1.7.6 Case Maintenance Fee RA Field Descriptions

Field	Description
PROV	The provider's HCs referral number.
RA NUM	This field indicates the number of the RA for the provider during the current financial cycle.
RA TITLE	This RA page is titled: Case Maintenance Fee.
SEQ NO	This field indicates the RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	This field indicates the date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
NUM OF PAID CLAIMS CURRENT	Not used for this report.
NUM OF PAID CLAIMS YEAR-TO-DATE	Not used for this report.
NUM OF DENIED CLAIMS CURRENT	Not used for this report.
NUM OF DENIED CLAIMS YEAR-TO-DATE	Not used for this report.
NUM OF PENDED CLAIMS CURRENT	Not used for this report.
NUM OF PENDED CLAIMS YEAR-TO-DATE	Not used for this report.
NUM OF ADJUSTED CLAIMS CURRENT	Not used for this report.
NUM OF ADJUSTED CLAIMS YEAR-TO-DATE	Not used for this report.
NUM OF VOIDED CLAIMS CURRENT	Not used for this report.
NUM OF VOIDED CLAIMS YEAR-TO-DATE	Not used for this report.
NUM OF CASE MAINTENANCE FEE CLAIMS CURRENT	Not used for this report.
NUM OF CASE MAINTENANCE FEE CLAIMS YEAR-TO-DATE	This field will be 0.
CLAIMS PAID AMOUNT CURRENT	Not used for this report.
CLAIMS PAID AMT YEAR-TO-DATE	Not used for this report.
CASE MAINTENANCE FEE PAID AMOUNT CURRENT	Not used for this report.
CASE MAINTENANCE FEE PAID AMOUNT YEAR-TO-DATE	This field will be 0.00.
INCREASE DUE TO CLAIM ADJUSTMENTS CURRENT	Not used for this report.
INCREASE DUE TO CLAIM ADJUSTMENTS YEAR-TO-DATE	Not used for this report.

Field	Description
NON-CLAIM PAYOUT AMOUNT CURRENT	This field indicates the amount paid for case maintenance fees (HCs) during the past week.
NON-CLAIM PAYOUT AMOUNT YEAR-TO-DATE	This field indicates the dollar amount paid for case maintenance fees (HCs) during the current calendar year. This amount equals the total of the non-claim specific payout amount fields on each RA during the current calendar year.
RECOUPMENT AMOUNT WITHHELD CURRENT	Not used for this report.
RECOUPMENT AMOUNT WITHHELD YEAR-TO-DATE	Not used for this report.
AMOUNT WITHHELD DUE TO CLAIM ADJUSTMENTS CURRENT	Not used for this report.
AMOUNT WITHHELD DUE TO CLAIM ADJUSTMENTS YEAR-TO-DATE	Not used for this report.
LIEN, PENALTY AND INTEREST WITHHELD CURRENT	Not used for this report.
LIEN, PENALTY, AND INTEREST WITHHELD YEAR-TO-DATE	Not used for this report.
TOTAL WARRANT PAYMENT AMOUNT CURRENT	This field indicates the total dollar amount paid for HC case maintenance fees processed for the past week.
TOTAL WARRANT PAYMENT AMOUNT YEAR-TO-DATE	This field indicates the total dollar amount paid for HC case maintenance fees and financial transactions processed during the current calendar year.
NET EARNINGS CURRENT	This field indicates the net earnings for the past week.
NET EARNINGS YEAR-TO-DATE	This field indicates the net earnings for the current calendar year. This amount equals the total net earnings on each RA for the calendar year.
REFUNDS AND RETURNED WARRANTS CURRENT	Not used for this report.
REFUNDS AND RETURNED WARRANTS YEAR-TO-DATE	Not used for this report.
OTHER ADJUSTMENTS CURRENT	Not used for this report.
OTHER ADJUSTMENTS YEAR-TO-DATE	Not used for this report.
TOTAL TAXABLE EARNINGS CURRENT	This field indicates the net earnings for the provider during the past week.
TOTAL TAXABLE EARNINGS YEAR-TO-DATE	This field indicates the total net earnings for the current calendar year. This amount equals the total of all total taxable earnings on each RA during the current calendar year.
MESSAGE CODE	Not used for this report.
EOB MESSAGES	Not used for this report.

A.1.7.7 Sample Case Maintenance Fee RA

PROV: 1234567 IDAHO MEDICAID REMITTANCE ADVICE
RA NUM: 8845621546
SEQ NO: 1 CASE MAINTENANCE FEE
PAGE NUM: 5 RA DATE 03/31/2004

F I N A N C I A L I T E M S

CLIENT LAST NAME CLIENT FIRST NAME

A/L NUM	CCN	MID	ICN	HVER	DNUM	TXN DATE	ORIG AMT	TXN AMT	BAL AMT	RSN CODE
751997205001000	701997205001000	7654321	201997128131000	01	01	06/23/2004	788.45	788.45	0.00	65

NET IMPACT OF FINANCIAL ITEMS: 994.00

FINANCIAL REASON CODES
126 PROVIDER – PAYOUT HMO

COUNTS	CURRENT
NUM OF PAID CLAIMS	0
NUM OF DENIED CLAIMS	0
NUM OF PENDED CLAIMS	0
NUM OF ADJUSTED CLAIMS	0
NUM OF VOIDED CLAIMS	0
NUM OF CASE MAINTENANCE FEE CLAIMS	0

WARRANT DATA		
CLAIMS PAID AMOUNT		0.00
CASE MAINTENANCE FEE PAID AMOUNT		0.00
INCREASE DUE TO CLAIM ADJUSTMENTS		0.00
NON-CLAIM PAYOUT AMOUNT		994.00
RECOUPMENT AMOUNT WITHHELD		0.00
AMOUNT WITHHELD DUE TO CLAIM ADJUSTMENTS	0.00	
LIEN, PENALTY AND INTEREST WITHHELD		0.00
*TOTAL WARRANT PAYMENT AMOUNT	994.00	

EARNING DATA	
NET EARNINGS (INCLUDES LIEN, PENALTY AND INTEREST WITHHELD)	994.00
REFUNDS/RETURNED WARRANTS	0.00
OTHER ADJUSTMENTS	0.00
TOTAL TAXABLE EARNINGS	994.00

*NOTE: IF TAXABLE SERVICES WERE PROVIDED YOUR ACTUAL PAYMENT AMOUNT MAY NOT MATCH THE TOTAL WARRANT PAYMENT AMOUNT.

MESSAGE CODES
000 NO EOBS THIS RUN
END OF REPORT